Provider E-Newsletter

Disclaimer: All information included herein is of an informative nature only. This newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from the Department of Medical Assistance Services (DMAS).

Volume III - Spring 2006

Upcoming Issues

- **ClaimCheck**
- **NPI**
- **PACE**
- **ARS/Web Registration**

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Dear Provider:

Here's hoping the spring finds everyone well. For providers new to the E-Newsletter, welcome and thank you for your participation. This is our fourth E-Newsletter (spring edition) made available to any provider requesting to receive it.

The intent of the newsletter is to inform, communicate, and share important program information with you. This edition has great information about our new Prior Authorization contractor, Payment Error rate Measurement Project, an update on FAMIS MOMS, and our latest National Provider Identifier (NPI) efforts.

Please share this information with colleagues and encourage them to sign up at www.dmas.virginia.gov/pr-provider_newletter.asp. Improved accuracy and timeliness of communication is critical to the DMAS mission and commitment to our provider community.

Thank you for your continued support of the Virginia Medicaid and FAMIS programs. Without you, Virginia's most needy citizens would go without medically necessary health coverage.

Sincerely,

Patrick W. Finnerty
Director

New Prior Authorization Contractor

The Department of Medical Assistance Services (DMAS) is pleased to announce the award of a new Prior Authorization contract to KePRO, an innovative healthcare management solution company. KePRO will conduct the prior authorization process for Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus clients in the fee-for-service programs that is currently being performed by WVMI and the Department.

Providers will immediately notice improvements to the prior authorization process such as:

- An internet accessible, web-based prior authorization interactive request and response function;
- A primarily paperless process for faster service and reduced provider administrative burden; and
- Utilization of InterQual criteria when appropriate.

Prior authorization functions will be phased in through May and June 2006 as follows:

- Phase I will be implemented in May 2006 and include outpatient psychiatric services;
- Phase II will be implemented June 1, 2006 and include the traditional services of inpatient review, outpatient review (excluding outpatient psychiatric services), and EPSDT;
- Phase III will be implemented in mid June 2006 and include the Medicaid specific services of specialized behavioral health, community based care.

Effective May 22, 2006**,** KePRO will handle the prior authorization functions for Outpatient Psychiatric Services formerly performed by DMAS. DMAS will continue to process all pre-authorizations, appeals, and pended cases with date of receipt up to and including, May 21, 2006.

DMAS will be issuing additional information to provider and enrollees in various mailings and educational presentations in April and May 2006. Site training and web-based training will be available statewide in April and May 2006.

Providers will be required to register with KePRO in order access the web technology. The form and process will be available by April 1st.

Further information regarding the new PA program will be available on the Department of Medical Assistance Service's website at www.dmas.virginia.gov and the KePRO website at www.kepro.org as it becomes available.

Thank you for your assistance as we move forward to improve the quality and efficiency of our prior authorization process. Should you have any questions regarding the prior authorization program, please send your inquiries via e-mail to PAUR06@dmas.virginia.gov.

Payment Error Rate Measurement (PERM)

Virginia has been selected as one of 17 states to participate in the Federal implementation of the Payment Error Rate Measurement (PERM) regulations during 2006. The Improper Payments Information Act (IPIA) of 2002 directs Federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review its programs that are susceptible to significant erroneous payments and report the improper payment estimates to Congress. The PERM regulation at 42 CFR §431.950 through §431.1002 (published in the *Federal Register* on October 5, 2005), directs the states to work with CMS in developing a national payment error rate to comply with the IPIA. The Department of Medical Assistance Services (DMAS) will work closely with the Centers for Medicare and Medicaid Services (CMS) and their partners to support this federal project.

The model can be summed up as follows: a statistically valid, random sample of adjudicated claims across all provider types will be selected and reviewed to determine the validity of the payments made. The audit will include an examination of the accuracy of the claims processing system and the medical necessity of the service for which payment was claimed. The dollar amount of any errors identified (underpayments and overpayments) will be tracked and used to calculate the final payment error rate for Virginia and become part of the national error rate for 2006. The Medicaid agency must report corrective action plans to address error findings.

For the first year of the project, CMS will use three national contractors to measure the accuracy of Medicaid fee for service payments made for services rendered to recipients.

- The Lewin Group will provide statistical support to the project by producing the claims to be reviewed and by calculating Virginia's error rate.
- Livanta LLC will provide the documentation/database support by collecting medical policies from the State and by collecting medical records from providers.
- A review contractor will be engaged in spring 2006 to examine the accuracy of the claims processing system and the medical necessity of the service for which payment was claimed.

Only a small number of the more than 35,000 Medicaid providers will be asked to participate in this project over the next year. The total sample of about 1000 claims will be identified quarterly from claims paid October 1, 2005 through September 30, 2006. The Lewin Group is currently preparing the sample for the first quarter (October through December 2005) and will forward the list of approximately 250 claims to both DMAS and Livanta LLC.

DMAS will notify providers who have been selected to expect a documentation request from Livanta LLC to support the medical review of the claim. The first medical record requests are expected to be generated in early April 2006.

For each sampled claim, Livanta LLC plans to contact the provider to verify the correct name and address information and to determine how the provider wants to receive the request(s) (facsimile or U.S. mail) for medical records. Supporting documentation must be submitted electronically or in hard copy within 90 days. If documentation is not provided, the amount of the claim will be considered an error, and repayment to the Medicaid Program will be required.

One of the goals of this new project is to identify claims processing procedures and medical policies that may contribute to increased payment errors. DMAS will work on corrective action plans to resolve any errors identified to ensure the most accurate payment rate possible.

As new information becomes available regarding the PERM project throughout the year, DMAS will provide updated information on the agency website at www.dmas.virginia.gov . Select Provider Services and General Information to locate PERM.

The cooperation of providers selected to participate in this project will ensure that the Virginia Medicaid Program is fully credited for all claims that are accurately paid. General questions regarding the PERM project may be directed to Sharon Long, DMAS PERM Project Director, at 804-225-4225.

DMAS FACTS

- Average number of claims processed per month: Over 4 million
- Amount of money spent on services in Fiscal Year 2005: Over $4.5 billion
- Number of active recipients receiving health benefits 832,905
- Average number of days for a claim to adjudicate: 10 days
- Number of provider Billing in the last twelve months: 25, 400

Coverage for Babies Born to FAMIS MOMS Enrollees

FAMIS MOMS
Covering Pregnant Women With Affordable Health Insurance

Although, delivery expenses are covered for FAMIS MOMS enrollees, expenses for babies born to FAMIS MOMS enrollees are not automatically covered by FAMIS or Medicaid and they cannot be added to the mother's case with only a DMAS 213 Birth Notification form. Unlike a pregnant woman covered by Medicaid or FAMIS Plus, the FAMIS MOMS mother must complete an application for the baby's coverage and be determined eligible. Following the birth a complete signed application must be submitted to the FAMIS Central Processing Unit (CPU) via fax at **1-888-221-1590** or by mail at:

FAMIS
PO Box 1820
Richmond VA 23218-1820

or at the family's local Department of Social Services (DSS) office.

Failure to submit a complete signed application in the month that the child is born may result in no coverage for the newborn for any charges incurred at birth including hospitalization and pediatrician claims. As such, a signed application should be filed as soon as possible after the child's birth.

If the newborn is found to be eligible for FAMIS Plus (children's Medicaid), medical expenses may be covered retroactively for up to three months prior to the date of application, but no earlier than the child's birth date. If the child is eligible for FAMIS, coverage can begin no earlier than the month in which the signed application was received at the FAMIS CPU or the local DSS office. Because there is no retroactive coverage for FAMIS, the application for a baby born on the last day of the month must be faxed to the FAMIS CPU that day.

In an effort to facilitate the submission of applications for newborns of FAMIS MOMS enrollees, the FAMIS CPU mails a pre-filled application to each FAMIS MOMS enrollee 30 days prior to her expected delivery date. DMAS encourages providers to assist FAMIS MOMS enrollees in faxing these applications directly to the FAMIS CPU at **1-888-221-9402** after delivery. Prior to faxing the application, please make sure the application is signed and includes the newborn's name and date of birth. For assistance and guidance in getting newborns evaluated for Medicaid and FAMIS coverage, contact the FAMIS CPU or the local DSS office about the FAMIS MOMS program. Families may also start the application process by calling the FAMIS CPU at 1-866-87FAMIS (1-866-873-2647) or by applying on line at www.famis.org.

MCOs covering FAMIS MOMS enrollees will also contact the enrollee before her delivery to remind her to contact the FAMIS CPU or local DSS office to apply for coverage for her baby.

National Provider Identifier (NPI) Update

In order to comply with the federal mandate regarding the NPI, the Department of Medical Assistance Services is targeting January 1, 2007 as the starting date for accepting either the NPI or Medicaid Identifiers in the transactions from trading partners. DMAS plans to notify providers six months in advance of the actual starting date of the transition implementation.

The Centers for Medicare and Medicaid has announced the availability of a new identifier for use in the standard electronic health care transactions. To read about the National Provider Identifier Activities, which began in 2005 please go to http://www.cms.hhs.gov/NationalProvIdentStand/.

The following information was obtained from the CMS List serve:

"Starting May 23, 2005, all health care providers can apply for their National Provider Identifier (NPI). The NPI will replace healthcare provider identifiers in use today in standard healthcare transactions. All HIPAA covered entities except small

health plans must begin using the NPI on May 23, 2007; small health plans have until May 23, 2008. For additional information, and to complete an application" go to http://www.cms.hhs.gov/NationalProvIdentStand/.

In addition to requiring Medicaid providers to obtain and use a NPI for electronic transactions, DMAS will be extending this requirement to all Medicaid transactions, including paper claims submissions, the Provider Call Center, the automated voice response system for eligibility and claims status (MediCall), and the web-based automated response system. DMAS will also be extending this NPI requirement to all Medicaid providers not considered health care providers under this legislation (atypical providers). These Medicaid enrolled "atypical" providers (personal care providers, respite care providers, etc.) will be notified in a separate memorandum.

DMAS strongly recommends that providers obtain a NPI as soon as possible by contacting the National Plan and Provider Enumeration System (NPPES) at 1-800-465-3203 or online at https://nppes.cms.hhs.gov. DMAS plans to begin allowing the dual use of both the NPI and the provider's current Medicaid identification number by January 1, 2007.

DMAS will be sending out memoranda to all Medicaid providers over the coming weeks describing the DMAS NPI transition process as well as key milestones and will continually update its website www.dmas.virginia.gov.

DMAS will also be using this opportunity to eliminate incorrect and outdated information on current provider files to ease the way for this federally mandated NPI transition. Providers will be receiving written information from the First Health Provider Enrollment Unit identifying the current demographic information DMAS has for every provider number and will be asking providers to respond in a timely manner to validate the DMAS database. It is extremely important that providers do so to make this transition process as smooth as possible. In addition, the First Health Provider Enrollment Unit will be requesting provider NPI number(s) to create a crosswalk to a provider's old Medicaid identification between June and December of 2006.

It is the intention of DMAS to make sure that this transition is deliberate and thorough. DMAS will make every attempt to clearly communicate to providers what will be required of them and will reduce, as much as possible, any burden this federal requirement places on a provider's ability to participate with DMAS. Giving attention to these pending changes will ensure that provider claims will be paid in an accurate and timely matter.

Provider Call Center Tips

DMAS is constantly striving to improve the quality and productivity of our Provider Helpline.
The Call Center answers over 11,000 calls each month most within 5 minutes of less.

Best times to call are:

First thing in the morning 8:30 - 9:30 in the AM
Late afternoon between 4:00 - 4:30 in the PM